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All were schuapps drinkers and the mental symptoms followed an early and serious epileptiform attack, the temperature rising to 41.8° C. and death supervened in several hours. The clinical picture was that of a severe delirium with marked motor restlessness, clonic spasms of the limbs, ataxia, paraphasic speech disturbances, heart weakness and cyanosis. At autopsy there was found cirrhosis of the liver, fatty degeneration of the kidneys, degeneration of the Betz and Purkinje cells, slight neuroglia proliferation, small cortical hemorrhage and grave alterations of the capillaries, but no traces of any inflammatory process.

Un Cas D'Amnesie Continue Avec Asymbolie Tactile, Complique D'Autres Troubles. B. BOURDON and M. DIDE. *L'Année Psychologique*, 1904. pp. 84-115.

The authors relate a very valuable and interesting case of tactile asymbolia, and it may be well in this connection to call attention to Liepmann's famous case of one-sided apraxia (motor asymbolia), since it has lately come to autopsy. (Das Krankheitsbild der Apraxie motorischen Asymbolie, auf Grund eines Falles von einseitiger Apraxie. *Monat. f. Psychiatrie und Neurologie*. Bd. VIII. H 1, 2, 3, 1900.) Bourdon and Dides's patient was a man 54 years of age, with a negative family history, married, and the father of three healthy children. He never had any serious illness; had received a fair education and was able to read and write. Four months after entering the hospital at Fougères, he had an episode in which he became violently agitated and was transferred to the Asylum at Rennes on April 19, 1902. Without any shock that could be observed, there suddenly occurred on May 3, of the same year, complete word blindness without mind blindness. He recognized and correctly named objects which were shown him, there was no word deafness or agraphia, he was able to write his name spontaneously and could write correctly from dictation, but copying was impossible. He also showed a tactile asymbolia (loss of the faculty of recognizing objects by touch) and a moderate degree of astereognosis (loss of the faculty to recognize the shape of objects by touch). On Sept. 9, 1902, there was a slight shock, the patient became confused and showed nearly complete word deafness. This symptom diminished, but on Oct. 16, there supervened another agitated episode, he pronounced disconnected words and threw objects about the ward. From this he went into a state of religious exaltation, in which he knelt and prayed a great deal and pronounced phrases devoid of sense. Once he said, "I am not an idiot, do not try to mix me up." On March 10, 1903, there was another slight shock, the mouth was turned slightly to the left, the eyes to the right and the cheeks were flaccid. He lay in a stupor, completely unconscious, the legs were drawn up and the reflexes exaggerated. He improved rapidly within the next few days and recognized and correctly named his relatives when visited by them.

ANALYSIS OF THE CASE.

An examination of the eyes showed the fundus to be pale, there was a narrowing of the visual field and probable diplopia, but no dyschromatopsia. Hearing was not impaired. Taste was good, but he was unable to name the solutions. Smell was fair, and although he could not name all the odors, yet he reacted well to disagreeable ones. The pressure sense was diminished, the temperature, pain and weight sense were normal. In tests for the tactile sense, the results were confusing. The muscular sense of position was intact. In testing the *stereognostic sense*, it was found that he did not know simple objects, but at times could recognize them, better by sight and touch associa-

ted, than with touch alone. At times, when he did not seem to know an object, he was unable to recall its name. By touch alone he easily identified such impressions as dry, rough, moist, and with more difficulty the forms square, round or the nature of an object (wood, metal), or the totality of an object (knife, hat). When the eyes were covered, and figures traced on the skin, he failed to recognize them; neither could he recognize by touch alone such objects as knife, scissors, hat, although he knew that the latter was something for his head. He knew a wooden triangle had three points, but he was unable to name it. He called a knife "a sponge" a box of matches, "a pen," but he was able to remove a match from the box and light it correctly.

He was able to distinguish the difference in the size of objects, but did not know their form. Simple objects were recognized, but he named them with difficulty or not at all. He recognized ordinary sounds (ticking of watch, clapping, grunting), and also popular songs. There was a general enfeeblement of the muscular force, as shown by the dynamometer. There was no Romberg. Orders for movements were executed only fairly well, due to a certain degree of word deafness, as shown by the following specimen of conversation. What is your name? "Laigre." How old are you? "Laigre." How old are you? "Oh, yes." How old are you? "Laigre." Letter and word blindness were nearly complete. He had some difficulty in pronouncing long words. He could not name simple letters, either written or printed, could not copy and was able to write spontaneously only his own name. The inner language (counting mentally) appeared to be fairly well preserved. He was disoriented for time and place and was unable to find his bed on the ward or his accustomed place at the table. He gave the alphabet correctly, named the months, days, Lord's Prayer and the ten commandments and was able to count but not by twos. The remote memory was not especially impaired. The patient died soon after these examinations, but the examination of the brain is not yet completed.

The *summary* of the case presents the following chief points: There is nearly complete letter and word blindness, but very simple objects are recognized by sight, therefore there is no mind blindness. The stereognostic sense shows a deep disorder. The patient easily identifies such impressions as dry, wet, etc., but he fails to recognize by palpating alone, unless he sees them at the same time, such objects as knife, scissors, hat, etc. He is unable to distinguish his right from his left hand. Although he understands simple, elementary sounds, yet word deafness exists. The movements of the hands are badly executed and slow. Speech is preserved, but there is paraphasia. He is able to write, but cannot copy, as he has lost the faculty to read and also to reproduce very simple figures by design.

It is necessary to distinguish the disorders of perception of the isolated properties of an object, from those of an object in its totality. Astereognosis is found in paralysis, ataxia and chorea and is the result of motor disorders. It also may occur in cortical lesions, which Wernicke has called primary identification. Tactile asymbolia is tactile blindness, that is, a rupture of associations between the centres of musculo-tactile images and the centre of visual images. The stereognostic perception comprises a plurality of sensations. Goldscheider (*Physiologie des Muskelsinnes*, 1898) shows that articulations and tendons have three elementary sensations, viz.: movement, weight, and resistance. According to him, it is the deep articular sensibility in which lies the sensation of movement. He considers the sensation of weight as a sensation of tendons, while the sensation of resistance is produced by the pressure of the articulations against one another.

Memory also enters into the stereognostic sense, and it is necessary to make the following distinctions, viz.: disorders of immediate memory, amnesia for recent and remote events, a failure of fixation of memory for recent events, and retrograde and ante-retrograde amnesia. From a pathological standpoint, the amnesias may be classified as follows: (M. Dide—*Essai de Classification des Amnésies*, Bull. de la Société Scientifique et Médicale de L'Ouest, 1903, p. 456.)

1. Amnesias due to a general enfeeblement of the intelligence, the memory diminishing progressively and in a parallel manner with the other elements of the intellect, as in general paralysis.

2. Amnesias due to alterations in the sensory sphere, in particular in the visual cortical sphere, which shows that very limited lesions in the visual cortical region give the clinical picture of continued amnesia, or there may arise a loss of topographic ideas (topagnosia) in amnesias due to the same lesion. These occipital amnesias, may be divided into agnosias, if the formation of mental images does not take place (psychic blindness) and into aconamesias, if the image is obliterated while being formed (amnesias by fault of fixation).

3. Amnesias due to mental confusion (intoxication, epilepsy, uremia, acute alcoholism, polyneuritic psychosis).

4. Amnesias due to a diminution of the capacity of attention and a weakened will power (amnésies abouliques) as may occur in neurasthenia and certain melancholias.

Applying these data to the case in question, the authors claim that perhaps the marked degree of tactile asymbolia, is in great part the outcome of the enfeeblement of the immediate memory, of the memory for recent events, and of the poor motor co-ordination of the hands. The patient handled an object poorly and he took a long time to palpate his hands over the contours of an object, and in this manner he forgot that he palpated a certain part of the object. The different sensations did not come together, and therefore he was unable to produce a mental picture of the object in its totality (lack of the "sense of fusion"). The hypothesis that tactile asymbolia results from a destruction or enfeeblement of the visual images is perhaps true, because objects seen were easily recognized. There is a rupture of associations between the centres of tactile and those of visual images. The anatomical findings may perhaps clear up some perplexing problems in localization.